SOCIAL IDENTITY AND SELF-CONTROL

by

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Introduction: The Problem of Classification

A plan of research in any field of science must depend, in the last analysis, upon the phenomena being investigated. By this we mean that if psychopathological states are the concern of social psychiatry - as they are the concern of any branch of psychiatry - we must begin with the character of such states at least insofar as present-day psychiatry understands them.

It has been argued that "what is normal", or some relativistic concept of normality, lies at the root of such questions since conduct and behavior vary noticeably from one community to another. A few decades ago, Ruth Benedict stated that the "normals" of one culture might seem to be the "abnormals" of another, that is, their behavior would seem strange in alien cultural contexts. This passing and plausible observation had added to it the astonishing corollary that out-and-out abnormals of one cultural context could "fit in" somewhere else, something which the author had occasion to test, and which he found to be incredibly naive, in studies among Northwest Coast Indian schizophrenics, found together with Eskimo and White psychotics in the Morningside Clinic and Hospital, a federal institution in Oregon. Illness, in short, represents impairments in functioning destructive of any individual's integration in his adaptation to any context or to his adjustment in any scene. The accurate point, from culture to culture, is not that such deviancy can find a haven elsewhere, but that it is etiologically traceable to stresses implicit in a social and cultural background.

In contrast with this last point, psychiatry has its time-honored classifications of mental disorders which date back to the last century with little modification. These categories are based, not upon etiology nor upon dynamics, but upon clusters of symptoms. The fact that many such symptoms, like hallucinations, feelings of depersonalization, etc., are found cross-culturally argues of course for the existence of general illness classification (the schizophrenias, neuroses, and the like). At the same time, the overlapping of many elements such as "asocial withdrawal", "restlessness", "sexual identification problem", or their incorporation into illness states of varying degrees of seriousness, links up very well with what we know of culturally varying types within such single or generic classifications like the schizophrenias. Both sets of facts denote or point to a necessity for new, etiological classifications within the more generalized rubrics.

If this is so, most studies of generic categories like schizophrenias, alcoholism, character disorder, etc., have been, statistically speaking, studies of apples and oranges which do not sort out the predominant, descriptive and independent variables which cut most deeply. Social psychiatry has exactly these etiological interests for it is concerned ab initio with the impact of culture, social environment and family type upon the developing personality. It can reach this goal only if it maintains a focus upon both facets of the problem: the incidence and the variations of psychiatric disorders. Both of these foci are important at the same time. There is a growing faith among social psychiatry personnel that all is well if the study is one of incidence of psychiatric disorders in general. Having participated in the Midtown Study in New York, where we sought the prevalence, treated and untreated, of mental ills throughout a whole population, the author can note that even criteria like "impairment in life functioning", together with symptoms, do not describe wholly the degrees of adjustment, adaptation, or the measure of seriousness of an illness. A psychiatrist knows this insofar as he knows the history of a case in its total setting. The quality of knowing is pre-eminently important. In our opinion, there is no good substitute for studies in depth of the individual in settings of family and sociocultural environment; and these are the methods used both by anthropology and social psychiatry. In measuring degrees of seriousness of an illness, one requires in psychiatry, as in other branches of medicine, some knowledge of the total case, of prognostic indicators, of personality assets and liabilities in a known family and community environment, — in short, a wide variety of information involving etiology and dynamics.

Earlier Approaches to Disease Classification

Of all the fields of knowledge, man's discovery of himself has come most recently in human history. First, in the heliocentric and planetary motion theories of Galileo and Copernicus, came man's discovery of the heavens. Then with Lyell, the earth sciences were solidly established. The acceptance of Darwin's discoveries completed the gains made in the 19th Century. Freud, of course, followed in the 20th Century.

In conceptions of health and illness, likewise, the cosmic and astrological theories precede the earthly ones. Plato, for example, spoke of disharmony and disproportion of four universal or cosmic elements, earth and water or fire and air. He thus projected illness out into an anonymous universe with which the sick were simply out of step or out of tune. Stoics, like Buddhists elsewhere, believed suffering was just a matter of individual judgment and urged calm detachment in the face of pain. A Hippocratic version of disease made it more a part of human existence, but restricted illness to its own sphere in life processes in order to study its various manifestations. Not till Galen was the challenge uttered, "Man is a whole with his environment". But to the Paris Medical Faculty in the Middle Ages, this could mean merely noxious agents in earthly environment such as "atmospheric causes" of the Black Death, or the Italian peasant's mala aria (literally "evil air") in a miasmic theory of diseases (1, 2).

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[1]Erwin H. Ackerknecht, A Short History of Medicine (New York: Ronald Press, 1955.)

[2]Walter Riese, The Conception of Disease (New York: Philosophical Library, 1953).

From cosmic theories to those of gross and earthly noxious agents, one goes from fate or fatalism to that long advance in theory that at least places man in his earthly environment. Yet the earthly theories of noxious agents, propounded during long centuries of an age of agriculture, retained their own brand of fatalism implicit in man's dependence upon such gross forces of nature as wind and weather. When atmospheric and miasmic theories became converted to theories of internal juices ("humors"), doctrines of internal assault held sway. Not till micro-organic life was understood, with Koch and Pasteur, could the theories of internal assault be refined. Later Claude Bernard, Walter B. Cannon and Sigmund Freud demonstrated the essential unity or integration of the human being, physiologically and psychologically. With this step, the door was opened to awareness that human values, emotional attitudes and habits played their role in the disease process. A sociologist like Talcott Parsons could search for roots of various psychological patterns and influences within human societies and their social processes. A psychiatrist like Kardiner could speak of different kinds of social emotions as being patterned in social structure. Anthropologists could investigate these patterns for clues as to their origin in cultural experience (3).

Cultural Process Versus Cultural Stereotype

Following Darwin, evolutionary schemes applied to culture offered a way of explaining or analyzing, rather than merely describing, man's world (4). Some of these early doctrines of cultural evolution stressed a simultaneous progression from simpler to complex forms in both biological and cultural realms. The task Herbert Spencer assigned himself, of defining a universal law of progress, expressed in his First Principles, emphasized simultaneous biological, psychological and cultural development, making the former the precondition for the latter. Others, like Lewis Morgan in the United States, wavered between ideas of biological evolution governing the slow progress through stages of cultural development, and his much more greatly emphasized and contrary idea that technical progress influenced both cultural evolution and the developing "germs of thought" even affecting factors such as brain weight. These confusions in the often conflicting theories of Spencer, Morgan, McLennan, Tyler or Westermarck meant there was much unfinished business in 19th Century anthropology. It led American anthropologists of the 20th Century, following Franz Boas and Robert Lowie, to fall back on descriptions of particular cultures and on regional descriptive classifications rather than attempt formulations of general cultural processes. This last movement was more reminiscent of a Lamarckian description and classification than of a Darwinian analysis of process (5).

Much of the Spencerian type of theory of a simultaneous evolution on all levels, biological, psychic and cultural inevitably stressed inadequacies of early man, nonliterate cultures, and of so-called, contemporary "primitives". In anti-racist American anthropology, this early evoked, as in Franz Boas' book, The Mind

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[3] Iago Galdston (Ed.), Beyond the Germ Theory (New York Academy of Medicine: Health Education Council, 1954.)

[4] J. H. Steward, "Cultural Evolution", Scientific American: 194:69-80, 1956.

[5] M. K. Opler, "Anthropology": In P. L. Harriman, J. S. Roucek (Eds.), Contemporary Social Science (Harrisburg, Pa.: Stackpole, 1953.)

of Primitive Man, a cogent defense on psychological and cultural grounds of any Homo sapiens on all continents and in every world area. Henceforth, in the leading position of American anthropology, mental processes were linked firmly with cultural ones, "race" was demolished as an explanation of culture, and psychological stereotypes could no longer stand for either cultural development or particular cultural systems.

The search for given cultural patterns, and awareness of their variety and difference, led in due course to revivals of more psychological descriptions of them, as in Ruth Benedict's Patterns of Culture. While descriptions of particular cultures in terms of pattern or personality type multiplied, the central problems of how personality or pattern originated were not always convincingly analyzed. The Benedict position, for example, involved a circularity between pattern and personality which was hardly an explanation. Subsequent zonal theories of a Freudian basic personality patterning were so limited in their range of description of possible behavior in a given culture as to lead to rebuttals to the effect that these elements or aspects did not encompass either the personality range in a Freudian sense or the behavioral range in the culture at all (6). It appeared in the simpler accounts, that the racial stereotypes of the 19th Century were rapidly being replaced by personality stereotypes of the first half of the 20th. For one thing, the statistical frequencies of various illnesses, or of personality types and problems, had to be better known. For another, it was necessary to study in greater depth than hitherto the development of personalities in well-understood cultural settings inasmuch as human reactive and adjustive systems were, in all probability, not simple closed systems of adaptation, but complex, open and integrative systems in which much more than one organic locus or set of personality characteristics operated at a time.

In addition to this complexity, in which one organ system or another could substitute in taking the brunt of strain, and in which personality had to be viewed as a more or less precarious balance, there was the question of universal cultural values, or human values as such, which might be operative irrespective of particular boundaries. All cultures, as a general phenomenon, were instrumentalities in providing some control over nature and adaptation to environment. All, therefore, contained such modalities as economic systems, or the organized provisioning of food, shelter, and protection within variable limits. All regulated social and sexual conduct. All contained explanatory devices in ideology, whether in myth, science or philosophy; or provided some modicum of relaxation in arts, literature, play and the like. These least common donominators, expressing universal values, gave some unity to culture as a generic phenomenon despite historical or evolutionary differences in the various means for their attainment. Thus, culture was a resultant of human activity and a precipitant of further social systems of action.

For this reason, adequate cultural descriptions or analyses, because of their generalized character, were not stereotypes in the sense that racial or psychological characterizations of whole peoples were. They corrected the Tweedledum and Tweedledee theories that all persons had exactly the same ideological or psy-

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[6]M. K. Opler, Culture, Psychiatry and Human Values (Springfield, Ill.: C.C. Thomas, 1956.)

chological characteristics. At the same time, the whole realm of systems of meaning, patterns of emotional response, and effects of culture on personality could be searched as part of the study of cultural process.

Illness and the Socio-Cultural Process

We have seen that one aim of anthropological research was not simplistic description of stereotypes, but rather research into the procosses of cultural growth in which one aspect is the dynamic relationship between culture, on the one hand, and statistical frequencies of personality types within cultural boundaries on the other. A research model for this inquiry must contain persons some of whom represent the culture at its best, and some at its worst. Thus an interest in illness, from this vantage point, hardly implies that the most positive and creative aspects of the culture are exemplified by one illness type or by illness types found in it in general. Yet the description of a culture includes its disorders and their frequencies of occurrence, since illness is never a private problem either in origin or in effects. Parsons has noted the ability of illness to disrupt the smooth functioning of social systems and the stylized methods used in cultural systems for dealing with these effects (7).

In respect to more scientific controls, it was not until man's protective and reactive functions were revealed by Cannon and by Freud that the control and prevention of disease was effectively extended beyond those illnesses having a specific, isolated pathogenic agent. J. L. Halliday, in his book, Psychosocial Medicine, has therefore defined illness generally as the reactions or responses of an individual to those forces encountered as he functions and develops in time (8).

However, with humans, we are all too prone to assume that these responses are the isolated reactions of individual organisms. Since culture itself is a human agency or organization of instrumentalities for adjusting and adapting to nature, its functions do not cease with the illness process. We can report that individual reactions are mediated by a whole system of values, attitudes and behaviors which are not exclusively possessed by any one person in a culture. By furnishing guidelines to behavior, culture over generations enters into the illness process (9).

Cross-cultural comparative studies indicate that even such ills as heart disease, hardening of the arteries, or the human organism's vulnerability to intestinal amoeba are anything but inevitable and invariable organ reactions. F. S. C. Northrup reports a Latain American country in his experience with a pleasant lack of our efficient conceptions of time; they also had a pleasant rarity of our heart disease or arteriosclerotic conditions among the elderly. In Burma and Thailand, American health teams and technical aids must be eternally vigilant about water supply and its amoebic hazards. But the village populations, even down to the smallest children, seem relatively immune to many of these conditions either through natural selection over time, or through the immunity built up from the earliest years. On the broadest, world-wide basis, the physical anthropologists,

[7]Talcott Parsons, The Social System (Glencoe, Ill.: Free Press, 1951.)
[8]J. L. Halliday, Psychosocial Medicine (New York: Norton, 1948.)
[9]M. K. Opler, Culture, Psychiatry and Human Values (Springfield, Ill.: C. C. Thomas, 1956.)

Coon, Garn and Birdsell have shown how certain body builds such as the Eskimo pyknik or barrel-shape, even down to small noses and fat cheeks, are fitted to circumpolar survival, whereas the tall, asthenic build and aquiline features of Sahara dwellers are better adapted to the heat they must endure (10). Alfred Hess' studies of diet deficiency diseases could be adduced for a modern, urban example of environmental effects (11). Certainly, the individual and his environment are not mutually exclusive systems.

While most organisms react directly to inborn, organic potentials and outer stimuli, humans are both more sensitive reacting systems, and more complex self-regulating systems. One of Cannon's most interesting papers concerned schizophrenic fear reactions in different nonliterate cultures resulting from the breaking of social group taboos. The guilty individuals, or those victimized, impressed by the taboos and their magical death sanctions, literally wasted away and died (12). Any psychiatrist can think of similar modern occasions where unmet or extravagant emotional needs of one or more parents were fulfilled at the expense of the child. Robert Lindner's Rebel Without a Cause was such a case, though a less seriously damaged one (13). It is significant that Lindner states in the first two pages of his book that psychopathic behavior is relative to, or stems from, the culture in which it develops. His patient's illness is measurable only by the prevailing ethic or morality. He concludes that any prevailing psychopathology or any illness is relative to the culture in which it flourishes.

Not only do psychological and physiological processes integrate or interweave in the individual, but community pathology may reflect these precarious balances on a statistical level. Illnesses like certain forms of diabetes were prevalent, for whatever reasons, in Italian and Jewish populations. Alcoholism is relatively common among Irish, but rare among urban Chinese (14). Beyond this, there are community reactions to health programs in which conceptions of illness play a role. Dr. John Cassel reports the difficulties of promoting milk or egg consumption or restrictions of grazing lands among Zulus where cattle are important in ancestor worship and connected with ideas of proper conduct. Parallel difficulties were encountered among sheep-herding Navajos of the American Southwest because of attachments to a mobile existence and the importance of tangible property in sheep. In the same volume, published by the Russell Sage Foundation, Drs. John and Elaine Cumming reveal social attitudes and beliefs about mental illness in a Canadian town, where the community, no more rationally than Zulus or Navajos, solved the problem by segregating those ill in a class apart and refusing to think of such illness as a community problem. Lyle Saunders

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[10] C. S. Coon, S. M. Garn and J. B. Birdsell, Races (Springfiled: C. C. Thomas, 1950.)

[11] A. F. Hess, Scurvy Past and Present (Philadelphia: J. B. Lippincott Co., 1920.)

[12] W. B. Cannon, "Voodoo Death", American Anthropologist:44: 169-81, 1942.

[13] R. Lindner, Rebel Without a Cause (New York: Grune and Stratton, 1944.)

[14] Oskar Diethelm, The Etiology of Chronic Alcoholism (Springfield: C. C. Thomas, 1955.) See study of New York Chinese by M. L. Barnett.

and Julian Samora consider the failure of a health association plan among seven thousand Spanish Americans of rural Colorado through neglect of local leadership practices and long-established individualized or more intimate approaches to those ill (15).

More optimistically, we recall the tremendous success of Japanese American community hospitals in Relocation Centers where Japanese American physicians and hospital committees mobilized to serve medical needs of barracks towns of ten thousand or more people. Here efficient organization developed almost spontaneously to insure health safeguards in a totally insecure population for whom other forms of security, -- economic, social and political, -- had virtually disappeared. In addition to effective hospital organization, the drive towards health revived a parallel and additional "safeguard" in ancient and folk methods of healing along with various magical means of coping with disaster none of which prevailed later in the mainstream of American life (16).

There can be no doubt, then, that all peoples value health, though their conception as to what good health is or how to obtain it varies with ethnic groups, generation levels and social classes. Action programs, aimed at health improvement or illness prevention, must start with existing health practices and behavior noting the integration of these elements in the general cultural system, and the functions they perform for those who practice them. In this light, a knowledge of a community and its people is as indispensable in health programs as a knowledge of the epidemiology of the area and the appropriate medical techniques.

In 1945, Dr. H. B. Richardson reported the results of a two-year study of the concept of the family as a unit of practice. The concerted efforts of general practitioner, psychiatrist, nursing and social work personnel, combined as a team, were assessed. The evidence was convincing that such an approach led to better diagnosis and treatment, less pressure on existing clinical facilities and faster progress towards medically sound solutions. Unfortunately, such teams are complicated in structure and most readily available, if at all, in institutional settings. Even so, education of such teams for community operation requires an understanding of cultural backgrounds in a community. Earlier, in 1940, Dr. Leona Baumgartner suggested that an understanding of the cultural backgrounds of various ethnic groups provided an implementation of more effective health programs (17).

Ethnic Variations in Concepts of Health and Illness: A Case Study

Lyle Saunders has illustrated the importance of providing medical advice in a way that is culturally acceptable to the community for which it is intended (18). The same is true of therapeutic efforts with individuals and families. In one Italian case involving urinary disturbance in a small girl, the public health

[15]B. D. Paul (Ed.), Health, Culture and Community (New York: Russell Sage Foundation, 1955.)

[16]E. H. Spicer, M. K. Opler, et al, Impounded People (Washington, D.C.: Government Printing Office, 1946.) Compare, M. K. Opler, "Japanese Folk Beliefs and Practices", Journal of American Folklore, 385-397, 1950.

[17]H. B. Richardson, Patients Have Families (New York: Commonwealth Fund, 1945.)

[18] Lyle Saunders, Cultural Difference and Medical Care (New York: Russell Sage Foundation, 1954.)

nurse reported the mother's refusal to have the child referred to a hospital clinic in the neighborhood from a child health station similarly located. After months of regretting she had divulged the matter to anyone, the mother reluctantly took the child to a neighborhood physician. Despite her devotion to the child, she could not bring herself to reveal the difficulty and seemed relieved when the child was pronounced, quite correctly, in fairly good health. During this period, she avoided the health station and refused to admit even the nurse in whom she had confided on routine call at her home. Instead she prayed for strength "to give" the little girl.

Many cultural beliefs are indicated here and we shall refer to them again in respect to a case of greater psychodynamic significance. Here the mother, a South Italian, first-generation woman of rural origin merely translated cultural attitudes directly into action. For one thing, South Italians of this generation frequently have an almost reverent attitude towards anything relating in their conception to the reproductive system. This concern and respect applies equally to females as to males, but girls are especially to be protected or shielded. As Phyllis Williams indicated, they are chaperoned by own siblings and by older female relatives in the nubile years, and protected by male relatives at all times previous to marriage. When young, like the child in the illustration, they are safeguarded by mothers (19).

In addition, later matchmaking for marriages must scrutinize such matters as venereal infection, mental illness and tuberculosis, each being in the most literal sense a shameful and feared blot on family reputation. In this case, it was later learned, the mother feared her own scant and irregular menstrual periods were possibly linked with some unknown mishap under the heading of venereal infection. Or if nothing else, scant and irregular menses mean low fertility and impaired femininity in this culture, something which again it is believed may be imparted to a daughter. In some areas of South Italy, feminine boasting or shame will be exactly on such bases, and women with scant flow would wash their napkins with those better favored to increase fertility. Theodora Abel and N. F. Joffe have reported the alacrity with which such information is imparted to the young at public feminine gatherings and included in the learning of sex role at puberty; or the insignia (red kerchief) sometimes worn by peasant women at such times (20). In the particular case of the small girl, we can well imagine the shame and worry of the mother, and no less the discomfort and guilt of the child.

In the case to be outlined below, menstrual difficulties appear and disappear, but a more sustained problem relates to food intake. In regard to food, South Italians have elaborate folklore. Earl L. Koos, working with the Committee on Food Habits investigating nutrition in sociocultural groups, noted the Irish, even over generations, favored the pork-pattern or beefsteak with potato and cabbage, The Czechs adhered to a heavy meat and potato dumpling combination, and Italians to a pasta with red vegetables or meatsauce diet. Italo-Americans state that one of the worst aspects of a hospital stay is the paucity of Italian foods. In southern

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[19]Phyllis H. Williams, South Italian Folkways in Europe and America (New Haven: Yale University Press, 1938.) Much of these data of Williams may be compared with recent fieldwork in New York City. Barring regional variation and generation changes, the comparisons were favorable.

[20]Theodora Abel and N. F. Joffe, "Cultural Backgrounds of Female Puberty", American Journal of Psychotherapy: 4: 90-113, 1950.

rural sections of Italy or Sicily, the producing and rearing of strong children is a matter of great importance. Red vegetables "make blood". Bread or pasta are natural grain foods. Fresh vegetables rather than canned ones maintain health and vigor essential for both men and women. Among the Japanese who prize vigor and potency, especially for males, there is the desirability of having pickled daikon (a phallic-shaped root vegetable) accompany practically every meal, both for taste and for the psychosexual reason of promoting male potency. Italians of both sexes prize proper food for similar reasons, whereas rural Puerto Ricans would merely see a reflection on the husband's potency if his wife failed to have children. Each of these geographically separated cultures tend to favor male virtues and values since the son, tilling and planting in his turn, carries on the family name and fortune. But of all three, the Italian most emphasizes relationships between food, girth and fertility, and apply these measures of sexuality equally to men and to women.

Again, while one is struck by the restraint, sobriety and dignity of many if not all Japanese social occasions, both social life and emotional expression among South Italians are pitched at a high intensity. In South Italy, social life centers in small towns that serve as the meeting ground of the surrounding locale. Robert Lowie, in his Social Organization, remarks on the campanilismo or community feeling which unites the persons within earshot of the common church bells. We can all remember A Bell for Adano, but few sense the importance of a central piazza flanked by this church, by a school or monastery, sometimes by an opera house, and always containing the village fountain. The scarcity of water alone would make this a pleasant place for general gatherings, but in addition no door is closed except at meal times and children rise and retire with their elders. Social life, combining young and old alike, is carried on out of of doors to a considerable extent, promoting an air of intimacy and frank expression "from the heart" that few other peoples possess in similar degree.

In addition, strong ties in a padrone system or even stronger ones of family intermarriages unite people of the same locale or paesani. These local in-group ties, resulting in dialect differences for the larger districts, often persisted in the street settlement patterns, by district, long after the inhabitants had migrated to this country. While second-generation districts, such as we have studied in New York, do not adhere to Williams' picture of a street for a former district, the pattern varies to one of relatives, often mothers and daughters living contiguously The sense of intimacy, the direct expression of emotions, the high marital rates, and the wide affective extent of the family characterize the Italian individual. The family, including unmarried sons and daughters and sometimes even collateral relatives is more in evidence than the narrower family of parents and children found among Irish, English, or Scottish descendants.

While in Irish families a mother or grandmother is usually the central authority in matters concerning the home and children, the Italian family recognizes the father as head or breadwinner, and the mother as the delegated, secondary authority. By the same token, the Italian mother is often closer to the children and their problems. In the first and sometimes in the second generation, the Italian mother manages the home scene on a budget provided by the husband and older unmarried sons. Women are expected to marry early. While this devotion

to male needs and the production of large families have been modified in this country, there are still more male dominance and family-centered life than characterize Irish families.

In South Italy, as in Japan, parent-arranged marriages usually with the good offices of go-betweens minimized inter-family friction and embarrassment. In Italy, the prospective couple met at Sunday family conclaves and dinners, or the young man, if more impetuous, conversed through the doorway with the whole protective armament of the girl's family in solemn array. In the United States, where family honor is less a topic of local gossip, these customs wear away; but courtships and marriages are still a matter of lively family concern. While also, persons of second and third generation do not arrange home births with midwives and with forty day house confinements as in the first generation, the women's interest in prenatal care, large babies and dietary safeguards is often promoted by a parental or grandparental generation. For the latter, heavy people are vigorous and good-natured; large babies are desired; and thin people are often ill-tempered. Elderly females of this type were once thought to be in all likelihood "witches" with the "evil eye". Pasta, oil and blood-making vegetables in prenatal diet link with these beliefs. To strike a compromise in inter-generation conflicts on this point, higher protein pasta are now manufactured commercially.

As we have seen in the opening case of this section, the birth of a malformed or stillborn child is not only a family tragedy, but it is also a sign of physical and sexual weakness and a parental disgrace. Besides large babies, which Japanese or Irish consider no great gain and perhaps even a maternal hazard, male children are preferred, a matter which is left up to personal preferences among Irish. In addition, Italians or Puerto Ricans allow a double standard to prevail in premarital or postmarital sexual conduct, enjoining chastity and submissiveness upon the subordinate distaff side while at the same time stressing male escapades and sexual impulsiveness. The Italian girl at first menses immediately assumes women's dress and household occupations. With Irish, the event frequently went unnoticed, even among women of the family, and only sacramental events like confirmation, the Eucharist, or matrimony mark social steps in maturation. Because of high rates of male and female celibacy in Irish, only a birth of a child, and its baptism, clearly denote the true assumption of the status of matron. In the mother-centered Irish home, this is a status position of enhanced authority and control. Thus, South Italians may be influenced by many folk beliefs connected with menstruation, prenatal diet, size of family and the presence or absence of male children, whereas Irish have virtually none. Not only are Italian babies swathed or bundled, but since women are thought to be vulnerable in birth or menstruation, they must be bundled to prevent a chill at such times, much as men wore a "cholera belt" or abdominal covering in colder seasons. Finally, since menstrual blood is antithetical to infants in Italian folk belief, even causing mares to abort or curing skin growths, the help of female relatives, or god-mothers, is needed at such times.

Equally, studies of pain-threshold differences have stressed the low tolerance standards of Italians for whom bodily functions are so important or body image so clear that stoical equanimity is out of question. Postoperative recovery rooms, particularly where older Italian female patients are involved are frequently scenes of voluble acting out. Obstetricians have repeatedly contrasted the variance between the young Japanese-American mother who views birth almost as a battle where pain cannot be conceded and the Italo-American girl who may be somewhat more relaxed about the whole process, or more openly exultant about feminine functions, but for whom women have no part of "male fortitude" where pain may be involved.

While therefore pain, or even hypochondriachal ailments are easily ventilated by Italians, Irish will often pride themselves on taking little notice of bodily functions. Persons who do so are peevish, morose or ill-tempered. The family scene is often the last place for the ventilation of bodily concerns or over-concern. While the Irish death-wake is a community rather than a family function, the help bestowed upon a prostrate Italian family which has suffered a death (and known as il consolo) more usually illustrates the solidarity of the extended family group and local blood ties, as do the reciprocal gift or money donations to a family in need, known as la pieta.

We have outlined just enough of South Italian and Irish cultural differences to indicate variations in family size and affective extent, in sex role, in concepts of health and illness, and in certain additional details of behavior. It is helpful to turn finally to the outline of a case which dramatizes, in a married couple, significant aspects of illness better understood through a knowledge of these cultural background conditions. The case is given in bare outline to preserve anonymity.

Synopsis of the case indicates a young, second generation Italian woman suffered from menstrual difficulties, hypoglycemia and obesity, migraines and metabolic upsets, all restricted to certain life periods in which particular life crises occurred. Each difficulty had its transient hysteriform character. Her Irish husband's difficulties were somatized only in acute ulcer conditions, of which the type will not be indicated in any revealing detail. Suffice it to say that his illness improved as hers worsened, and that the contrary was also the case.

It is not necessary to indicate the number of children of this marriage, except to state that at the wife's insistence the family was a large one. Her own parents were of South Italian extraction and her own family of origin contained only one female sibling. At the time of study, she was in treatment for both hysterical and hypoglycemic conditions, exacerbated by the pattern of obesity and one of night eating. As we shall see, her own ailments and her husband's represented in the main a microcosm of the clash of two cultural backgrounds, or better the stress systems of the two backgrounds exemplified in each case. Therefore, in the clash of personalities and in the balance of their difficulties, neither could improve singly without a worsening of the condition in the partner.

Just as menstruation was a focal point of her difficulties, so the birth of each child was a tempestuous event, followed in one instance by illness. The children's birth weights were uniformly excessive. Concern about their weight and subsequent health led in each case to excessive weight gains in the mother, each gain to be retained and added to during the next pregnancy. As a young girl, even in post-adolescence, she describes herself as slim and pretty, - as her mother had been. Following the last birth, and her husband's mounting disinterest in the children, her feminine assertiveness was signalized by profuse, extended and painful menstruation brought to his attention as an instance of her self-sacrificing motherhood. When this symptom failed to stir sympathy, it disappeared as dramatically as it had occurred.

The patient gave a history of having always rebelled, as some second-generation Italian girls do, against the authoritarian nature of her father's household. Yet there were no overtones. Feelings towards the father were extremely ambivalent. He was not only authoritarian; he was decisive, assertive and distinctly attractive. These characteristics, all good ones by Italian norms, had been freely exhibited in the home scene, in at least two occupational successes, and in other sudden impulsive decisions which proved successful. Her father's equally unguarded rejection of her in favor of a sister first unleashed hysterical tendencies. When the sister displaced her as to a certain occupational preference, or was overly protective in the chaperoning duenna role, the patient fulfilled all the cultural expectations concerning the solidarity of sisters, was self-effacing about the occupational aspirations and developed emotional tension symptoms. For the first time, night feeding patterns were used as an oral substitution for withheld affection. That self-esteem had suffered was indicated by other evidences of habit deterioration in dress and grooming. Headaches occurred in periods of tension.

Courtship, even without the family's usual interested participation in this culture, was an asymptomatic period. Marriage was viewed as a triumphal moment. Pregnancies were desired, but with each and the home conflicts engendered in her own household, migraines recurred. During pregnancies, nausea and the old tensions could only be checked by excessive night feedings. On the other hand, the husband's ulcers became worse when her headaches subsided. When her migraines and night feeding patterns were worse, his ulcers were better.

Her drive towards marital status, the sanctioned adult status in this culture, was a more aggressive and self-conscious attempt than is true of most Italo-American girls. In addition to the normative desire to marry, she parried paternal rejection by determining to avoid getting a husband of Italian antecedents. Her position, a stereotyping one, was that their authoritarianism and selfishness were to be avoided. (We are reminded, parenthetically, that Chinese girls in Hawaii rarely marry into Japanese households, and give both male authoritarianism and mother-in-law domination as the reasons for this avoidance; Romanzo Adams and others have indicated that attractions occurring between these two large population groups are served by Japanese girls marrying in far greater numbers into the less

authoritarian Chinese households where the authority is diffused or dissipated in a wider circle of kin.) In this case, the attraction to a second-generation Irish male was in large part because of his avowed opposition to "any authoritarianism," including opposition to his own father as well. The husband, however, had been raised to value neatness, perfectionism and rationality at all costs. As the spouse later discovered, he was no little dominated by an Irish mother, the more typical authoritarian pattern of the Irish household, against which he no doubt internally rebelled. Marital conflicts led to his periodically seeking refuge in his parental home, especially when the conflicts were bared by verbal argument.

In addition, the female patient alleged a difference between them in degree of sexual interest and attention. Rather than analyze this as being, in part, a cultural difference, which in this setting required the seeking of joint psychiatric help, the Italian tendency was to emotionalize the situation further, dramatize it in operatic fashion, and develop "blank spells" of a hysteriform nature. In such periods of excitation, both basal metabolism and oral intake took sharp upswings. The husband's rationalizing reactions to these periods of her disorder were along the line that he could not cope with the difficulty and was free of responsibility. During such periods, his ulcer problem was quiescent. When medical attention resulted in some gain in her facing her problem and a loss in weight occurred, she renewed her demands for her husband's supportive sympathy and affection. His condition promptly worsened, requiring hospitalization. Again with his convalescence, her cycle began with food substitutions for inadequate affection. The greater her spontaneity and frankness, traits congenial to Italian character and temperament, the more his discomfort grew with internal bleeding as a consequence.

Of special interest in the female patient are low frustration tolerance thresholds, vivid dramatizations of her difficulties and high impulsiveness. For her to convert sex drives to feeding patterns, or to find other ready "solutions" not reported here constitute the kinds of impulsiveness and action patterns for emotional expression which are poles apart from rationalizing, perfectionistic, planful fantasy behavior more characteristic in the Irish system of defenses. Her rebellion against parental disapproval, rejection and thwarting surveillance dated back to her teens, but did not include open warfare with a sibling in the tightly organized Italian family, or assertive modes of behavior more suited to Italian males.

Her husband's attachment to his mother, and the tendency for his ulcer to bleed when he faced the realistic picture of growing family responsibility is the opposite of this picture. The lack of a stable anchor image like her father, or of impulse control mechanisms, leads to literal incorporation techniques to prevent an alleged loss of love. Meanwhile, the husband's unsuccessful attempts to make her over in a maternal image as indicated in his preference in dress and hair style are thinly veiled fantasy. Her impulses in the balance of these interpersonal transactions are periodic, negatively hostile and self-destructive. His critical and perfectionistic drives are deeply marked by inner rebellion. One is reminded,

in the fantasies about independence, in the facile verbosity, in the critical attitudes and planfulness of the Irish patient that these same qualities, in a different personal setting, mark the genius of a George Bernard Shaw or James Joyce. But instead, in this man, one finds, at bottom, empty dependence, rationalization and anger covering and no doubt underlying the helpless somatizations of anger. Neither tensions nor aggression, - his with ulcer attacks or hers in fluctuating hysteriform illnesses represent the respective cultures in the sense of stereotype or epitomization, but both point to cultural stress systems, once the cultural system and its pitfalls are laid bare. In each case, illness is not wholly personal or exclusively cultural, but is both at the same time.

These are but two cases of the effects of culture on behavior and on health. Both, unfortunately, represent complex problems. The solutions are not wholly within the province of internal medicine, psychiatry, or social science, but require insights and knowledge from each contributing discipline. They illustrate effects of a massive system, called culture for convenience, upon the sensitive and reactive system of human personality. The latter is obviously an open system, interdependently organized with both psychological and physiological components existing in some type of balance or integration. Such complex organization of cultural, psychological and physiological elements is present in every one of us, and the requirement in health practice is to analyze adequately each component.